

PRIMARY HEALTH CARE EXCHANGE OF INFORMATION REQUEST
Medi-Cal Managed Care Program

This form is used for the purpose of exchanging practitioner and beneficiary information to enhance care coordination for Medi-Cal Managed Care beneficiaries.

BENEFICIARY INFORMATION

Name: _____ DOB: _____ Telephone: _____
Address: _____ City: _____ Zip: _____
SSN: _____ Medi-Cal #: _____

PRIMARY CARE PRACTITIONER (PCP) – INITIATING QUERY OR COORDINATION OF CARE

Practitioner's Name: _____ Telephone: _____ FAX: _____
Email: _____ Date of Last Visit: _____
Physical Diagnosis(es): _____

Current Medications: _____

Reason(s) for Request:

- | | | |
|---|---|--|
| <input type="checkbox"/> Depression or anxiety symptoms not responding to therapy | <input type="checkbox"/> Suspected Pediatric ADHD | <input type="checkbox"/> Suspected Psychosis |
| <input type="checkbox"/> Suspected Mood Disorder | <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Suspected Substance Abuse |
| <input type="checkbox"/> Other _____ | | |

Practitioner's Signature & Discipline: _____ Date: _____

After making a copy of the form for your records, give the original to the beneficiary to take to the Behavioral Health Practitioner (BHP) who will complete the response portion and return the form to you. Send results of CBC, LFTs, TFTs, U/A, EKG, and any relevant consults, procedure results, or information with your request.

BEHAVIORAL HEALTH PRACTITIONER- RESPONDING TO REQUEST

The PCP initiating this form is requesting behavioral health information for the above-named person. Please complete and return this form via the beneficiary or by faxing to the PCP.

BHP Name: _____ Telephone: _____ FAX: _____
Diagnosis(es): _____
Date of Last Visit: _____ Email: _____
Current Medications: _____

Recommendations or Response to the Request (attach information if necessary): _____

Practitioner's Signature & Discipline: _____ Date: _____